Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH
5555 FREDERICKSBURG RD STE 102
SAN ANTONIO TX 78229

Carrier's Austin Representative Box
#19

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Date Received
MARCH 7, 2012

MFDR Tracking Number
M4-12-2323-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "First of all, our initial claim was submitted to Gallagher Bassett on 8/11/11. On 9/6/11, we received the initial denial for payment. The carrier denied the claim per '218 Based on the findings of the review organization'. On this same day I called the bill audit department and was instructed to fax my reconsideration to 1-866-958-1043. On 9/16/11, we called for bill status and spoke to Teresa who indicated the adjuster 'rejected' the claim because 'notification was absent'. I spoke with Ali on 1/18/12 who then told me the reconsideration submitted on 9/6/11 was 'not showing in the system'. I confirmed the fax number I initially submitted the reconsideration with Ali and she said I had the correct fax number. Ali then advised me to call Juanita Mixon (adjuster). I called Juanita and left her a voice message indicating I was re-faxing my reconsideration to her attention. On 1/20/12, another follow up call was placed where we were again told the reconsideration was not received and to mail it. Finally on 1/30/12, Juanita called me and advised me to send my reconsideration by mail to P.O. Box 23812 Tucson, AZ 85734. This is precisely where I submitted it to on 1/20/12. On 2/10/12, another follow up call was placed. We spoke to Sandy who said the reconsideration for date of service 7/26/11 was received on 2/2/12 and was sent to the adjuster to be processed on 2/7/12. A denial for payment was received on 3/1/12, indicating it was being denied for 'late filing'. This is completely unacceptable. As indicated above, the carrier and the adjuster had been contacted numerous times and multiple attempts were made to submit the reconsideration for payment by fax and by mail. I cannot comprehend why the carrier would deny a claim for 'late filing' when they have acknowledged receiving our initial claim and denying payment on 9/6/11. The reconsideration was submitted numerous times and within the 11 month timely filing period…"

Amount in Dispute: $680.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A position summary was not submitted by the respondent.

Response Submitted by: Gallagher Bassett Services, Inc., 6404 International Pkwy, Ste 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours)	$680.00	$680.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.204 sets out medical fee Guidelines for workers' compensation specific services.
4. 28 Texas Administrative Code §133.240 sets out procedures for medical payments and denials.
5. 28 Texas Administrative Code §133.250 sets out procedures for reconsideration for payment of medical bills.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 1, 2011
   - 218 – Based on the findings of the review organization.
   - 197 – Pre-authorization/authorization/notification absent.

   Explanation of benefits dated February 24, 2012
   - B4 – B4 – LATE FILING PENALTY.

Issues

1. Is the respondent's denial reason codes '218 – Based on the findings of the review organization'; '197 – Pre-authorization/authorization/notification absent'; and 'B4 – LATE FILING PENALTY' supported?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied the disputed services based on "218 – Based on the findings of the review organization" and "197 – Pre-authorization/authorization/notification absent." 28 Texas Administrative Code §133.240(b) states, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under chapter 134 of the title (relating to Benefits – Guidelines for Medical Services, Charges, and Payments." 28 Texas Administrative Code §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care." Review of the submitted documentation, the division finds that the carrier's denial reasons '218' and '197' are not supported.

   The respondent denied the disputed services based on "B4 – LATE FILING PENALTY." 28 Texas Administrative Code §133.250(b) states, "The health care provider shall submit the request for reconsideration no later than 10 months from the date of service." Review of the submitted documentation, the division finds that the carrier's denial reason 'B4' is not supported.
2. Per Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the preauthorization letter dated July 18, 2011 sufficiently supports the Chronic Pain Management Program x 10 visits was approved by the carrier under authorization number 9148525 with a start date of July 12, 2011 and an end date of September 12, 2011. The requestor has supported their position that the disputed chronic pain management program for date of service, July 26, 2011 was preauthorized per 28 Texas Administrative Code, Section §134.600; therefore, the requestor is entitled to reimbursement as follows per 28 Texas Administrative Code, Section §134.204.
3. Per 28 Texas Administrative Code, Section §134.204(h)(5)(A) and (B), a chronic pain management program shall be reimbursed $125.00 per hour for a CARF accredited program. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. A CARF accredited program is indicated by using the modifier –CA. Review of the submitted documentation finds that based on the factual determination that the provider did not bill the disputed services with the –CA modifier, therefore, in accordance with 28 Texas Administrative Code, Section §134.204(h)(5)(B), the monetary value of the program will be 80% of the CARF

accredited value.

DOS July 26, 2011: $100.00 x 8 hours = $800.00

Per the requestor's *Table of Disputed Services*, the amount in dispute is $680.00, therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $680.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $680.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.